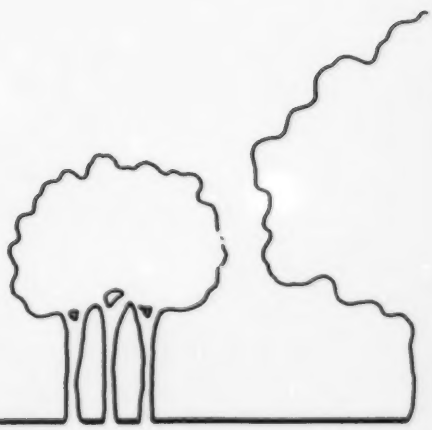
The Report of the P.E.I. Task Force on Health

Health Reform: A Vision for Change



Prince Edward Island Cabinet Committee on Government Reform

Letter of Transmittal

March, 1992

Hon. Joseph A. Ghiz, Premier
CHAIRPERSON, CABINET COMMITTEE ON GOVERNMENT REFORM
PO Box 2000
Charlottetown, PEI
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Dear Sir:

It is with pleasure that I submit the final report of the Task Force on Health.

The Task Force recognized that it was given a major opportunity to shape the future of health in the Province. I believe the Vision that is presented, when implemented, will direct the system in a way which is fiscally sound and is responsive to Islanders' needs.

The health care system, as represented by Task Force members, recognized that change is needed. Our very valued "public" representation wants change to occur and feel it is overdue.

Given the extent to which the review challenged the traditional approach to health delivery, agreement was not possible on all issues. However, Task Force members do unanimously support an implementation process that is well planned and takes the time required to involve health providers and the public in a new partnership.

I wish to express appreciation to the individuals who contributed to the outcome of this review - to those who coordinated the regional focus discussions with their tremendous teamwork and enthusiasm, to Jo Anne Ings, and particularly to Carol Anne Duffy who pulled it all together, thank you.

Task Force members see this Report as a major first step. They express their willingness to assist in the future stages of change.

Respectfully submitted,

D.W. Cudmore, M.D.
Chairman
Health Task Force

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GLOSSARY

HEALTH	*A state of optimal physical, mental and social well-being, not merely the absence of disease and infirmity (World Health Organization, 1978).*
HEALTH PROMOTION	*The process of enabling people to increase control over and to improve their health. (World Health Organization, 1987).*
COMMUNITY BASED SERVICES	*Health services which are provided in settings outside of hospitals and other residential institutions; community health service mandates include an emphasis on illness prevention, health promotion and maintenance.*
ENTRY POINT	*Place and/or person that is accessed by the public to receive a health service.*
HEALTH PROVIDERS	*All personnel, professional and non-professional, who are involved in providing health services to the public;*
HEALTHILY PUBLIC POLICY	*Public policy that encompasses all the determinants of health and is developed with an explicit concern for its impact on the health of society.*

EXECUTIVE SUMMARY

In June 1991, the Honorable Wayne Cheverie, Minister of Health and Social Services announced the establishment of a Task Force on Health.

This represented a major initiative of the Prince Edward Island Cabinet Committee on Government Reform and was in response to recommendations of the Hospital Role Panel Report (1991).

With a limited time-frame to complete its mandate, the Task Force relied heavily on the information obtained through the extensive and broad consultations conducted by the Hospital Role Panel. In addition, it had access to all recently published provincial task force reports and heard presentations on several major topics. The Chairperson, and several members of the Task Force, also attended five major focus groups where health care providers in the regions offered important observations and advice on the health system.

The Task Force concludes that the current health care system overly emphasizes the acute care component, commonly thought of as an illness system. Therefore, the new system must strive to achieve a balance among all the components of health care. This means its mandate must emphasize **health promotion and illness prevention, with a strengthening of community services.**

The Task Force recognizes that the public wish to assume a much greater role in the health care system. They must be given the opportunity to be more responsible for their own health and that of their community. They must be made more aware of the cost and complexity of health care and how to use the system wisely. This will require **extensive public education** and a mechanism for public input at both the provincial and regional levels.

The Task Force recommends that a **Provincial Health Policy Council** be established to develop provincial health policy and goals. It also recommends that the existing three Government management structures be consolidated into **a single management structure**, with its own board. This revised management structure will allow significant fiscal improvements by reducing duplication as well as increasing coordination of services. The single management structure must be supported by the establishment of regional organizations, which will determine local health needs and coordinate services at the community level. Regional organizations for service delivery was stated as a clearly identified need by the several hundred service providers attending the five community focus groups.

The Task Force also identifies strategies which must be considered as priorities for implementation by the new management structure. These include **a health information system, alternate methods of health care delivery** incorporating the **primary health care** model, **assessment of community needs, alternate methods of payment for physicians**, clearer definition of the **roles of the various health care providers**, and **utilization management** programs, particularly for institutional beds.

An important component of health care planning which the Task Force concludes has received inadequate attention is the ability to develop management strategies based on valid **outcome measurements**. One prerequisite for this is a comprehensive health information system for all components of the health care system.

The Task Force recognizes that the recommended changes will require reallocation of current fiscal resources, since additional new funding is not likely to be available. This will require **evaluation** and prioritization of existing programs and services.

An implementation plan is presented and may appear unduly prolonged. However, this report represents only the beginning of a process and as such, there is still much discussion to take place. It is considered essential to evaluate each step of this important new direction.

The Task Force was unable to address its third term of reference, a review of existing health legislation. However, it believes this task is a critical component of the implementation plan.

The Task Force believes this vision of our future health system is appropriate and when fully operational will preserve the ability to provide an acceptable level of quality health services at affordable rates for the residents of Prince Edward Island.

I. INTRODUCTION

In June 1991, the Minister of Health and Social Services announced the establishment of a Task Force on Health. The P.E.I. Cabinet Committee on Government Reform recognized the need for the health sector to examine its organizational structure, with a view to ensuring that the system can manage and provide services in the most cost-efficient and effective manner. The Cabinet Committee also identified that this review must follow a process of consultation, team building (partnership), and communication.

It was also recommended by the Role Panel Report (1991) that "different management structures be developed to manage health as an entire system" and that a process be established to develop "a clear statement of policy goals in health care for the province" (p. 32,33).

The Task Force, chaired by Dr. Douglas Cudmore, Medical Director of the Hospital and Health Services Commission, was comprised of the following individuals and their representative organizations:

Verna Bruce	P.E.I. Department of Health & Social Services
Angie Cormier	Wellington, P.E.I.
Beverly Deelstra	Montague, P.E.I.
Patrick Dobbin	P.E.I. Hospital Association
Dr. Kent Ellis	P.E.I. Hospital & Health Services Commission Board
Ken Ezeard	P.E.I. Hospital Association
Dr. Leo Killorn	P.E.I. Addiction Services
Barry MacMillan	P.E.I. Cabinet Committee on Government Reform
Dr. Robert Midgley	P.E.I. Medical Society
Joan Walsh	Association of Nurses of P.E.I.
Darlene Waugh	P.E.I. Department of Health, Social Services
Keith Wornell	P.E.I. Executive Council Office
Jeanette McAulay	Resource Person
Steve McQuaid	Resource Person

The terms of reference of the Task Force were:

* to advise, upon review of the existing policy development practice and tradition, on an appropriate structure or mechanism designed to consolidate policy leadership and development;

* to recommend a redesign of the health system's management and service delivery structures which is more fiscally efficient, avoids duplication and redundancy at both the provincial and community (regional) levels, and that is consistent with the goals and objectives of an integrated provincial health care system;

* to advise, upon review of existing legislation which defines and outlines the health ministry's mandate, on the necessary legislative and regulatory changes required to establish and administer a provincial health care system.

To assist the members in their deliberations, the Task Force was provided with a list of operating principles, that included the concepts of: a provincial system of health care, clear leadership, accountability, financial and resource efficiency, community-based and people-centered services. The principles also stated that there be increased emphasis on alternative models of health care with less emphasis on institutional beds and that the system be designed to reflect and respond to the health needs of the community and the individual and not the organization's (See Appendix A).

The recommendations of the Task Force are based on sources of information obtained through a variety of methods, including position papers, literature reviews, previous reports produced both in-province and out-of-province and frequent meetings and discussions of the Task Force members (See Appendix B). In addition, approximately 600 service providers met as five (5) focus groups in various centers across P.E.I. Major themes of these groups are listed in Appendix C. The active and willing participation of these health providers demonstrated the need for change and a sincere desire to be involved in the change process.

This report presents the rationale for a new system and the Task Force's VISION for health on PEI. To implement this VISION, the report recommends structures and strategies for change.

II. RATIONALE FOR CHANGE

The greatest challenge for the future of health care on P.E.I. is the maintenance of the quality of services that Islanders receive. Throughout the change effort, this must be the paramount objective.

The Task Force believes that residents of P.E.I. value heath care as something to be preserved and provided to all Islanders on a equitable basis, regardless of income or status.

However, the current fiscal environment continues to challenge P.E.I.'s ability to provide health care services. Annual health expenditures for P.E.I. currently are about $250 million or 1/3 of the total provincial budget. Added to this is the knowledge that increased expenditures on health care do not necessarily produce significant increases in health status (Sullivan, 1991).

The Task Force reviewed an abundance of reports that documented why change has become necessary if the health status of Islanders is to be improved and the quality of health care is to be maintained and enhanced, all without significantly increasing health expenditures. This rationale is presented as follows:

* A clear provincial direction for health care is lacking, as the system is not driven by goal-oriented provincial policy or leadership. There is a lack of healthy public policy, with little coordination of health policy development with other sectors of government such as education, youth and environment. In countries such as Japan and Sweden, where overall health indicators are better than Canada's, it has been demonstrated that important gains in health are achieved through public policy changes in sectors other than health (Sullivan, 1991).

* In reality, although the P.E.I. health care system is called a "system", it operates like a series of sub-systems. Government services are delivered through three major administrative structures, the Department of Health and Social Services, the Hospital and Health Services Commission and Addiction Services. Coupled with this are seven hospitals, nursing homes and community organizations. Each has its own structure of leadership, mandate and goals, often operating in isolation. This results in not only inefficient management structures but also excessive structures, if one considers the population of PEI is only 130,000 people. The need to provide effective management is critical if resources are to be used in the most cost-effective and appropriate manner.

* There is a lack of emphasis on health promotion and illness prevention, with insufficient community-based services. Modern disease and illness, for the most part, are of a preventable type. Much of our emphasis, however, continues to be on curing illness as opposed to preventing illness from occuring. A health care system, based on the principles of primary health care, will give health promotion and illness prevention a high priority, with a much stronger focus on wellness.

* In the absence of needs-based planning, many of the currently offered services have evolved over time. As well, there has been very minimal efforts to determine the effectiveness of these services; thus, allowing the continuance of some services which may have little or no benefit. In times of fiscal restraint, it is not only desirable but critical to determine the effectiveness of health services and allocate resources based on need. This will require the development of an Island wide comprehensive health information system.

* Health care costs are rising with greater public expectations, increased technology, the aging of society and increasing complexity of conditions being treated. Although per capita health expenditures on P.E.I. are one of the lowest in Canada at $1,534.00 for 1987/88, its percentage of gross domestic product spent on health care is one of the highest in Canada at 12% (Health and Welfare, Canada). This means that P.E.I.'s ability to spend more money on health is extremely limited. In addition, recent federal restraint measures have meant less than anticipated revenue sources for P.E.I. In view of this financial environment, it becomes even more critical that existing resources be managed to ensure a high quality health system is maintained.

* There is significant evidence of greater utilization of services in the health care system. In particular, areas such as physician services and laboratory and radiological procedures have been contributing to rising health care costs. The perception by the public of a "free" system and the open-ended, fee-for-service payment method for physicians can provide more. This coupled with physicians' fear of litigation contributes to greater utilization of services.

* There is an absence of adequate input to policy development and management decisions by the community and health providers, which fails to create a sense of ownership for the use and allocation of resources. It is recognized however, that in some cases, elected community boards are providing a mechanism for this input.

* Individuals are not actively involved in decision-making and taking responsibility for their own health or the health of their community. This applies to both health promotion activities and the treatment of illnesses. There is a need for individuals to make healthy choices about life-style practices and create healthy environments, while also accepting the limitations of the health care system. Through active participation, individuals can develop their responsibilities for not only personal health, but community and eventually societal health.

* The focus group discussions clearly identified that health providers not only lack clear role definitions, but there is inconsistency in their roles in different work sites. This causes frustration for both the health professional and the institution or service in which he/she is working. Also, it inevitably creates significant overlaps or gaps in the services being provided.

The Task Force believes that change is imperative if the system is to continue to provide a quality level of service. Furthermore, health providers and the public are requesting that government provide the leadership to ensure change is managed.

III. THE VISION

The Task Force, believes that if change is to occur and be managed, then there must be a clear picture of what is being pursued. The system must know the results it is trying to achieve. If the system has a VISION of where it wants "to be" then all actions and decisions on a daily basis can be directed towards "getting there". With this in mind, the Task Force developed its' VISION for health on P.E.I., as described by the following 10 principles:

The VISION for Health Care on P.E.I. is:

1) **PEOPLE SHOULD BE THE FOCUS:**

The primary focus of the health system should be the people. Therefore individuals receiving health care services should receive services adapted to meet their needs and not the organizations' or the health professionals'. Needs should be determined through formalized assessments, which will reduce the provision of services that are based solely on demand. Care must be provided at the level of least intrusion and disruption to the individual.

Individuals should be active participants in pursuing control over their own health, as well as the health of their community and society. They must have the necessary information to make healthy choices and use the system appropriately.

2) **HEALTH SHOULD BE ATTAINED THROUGH A GREATER EMPHASIS ON HEALTH PROMOTION AND ILLNESS PREVENTION:**

The system must strive to maintain wellness, in its broadest sense - physically, emotionally, socially, spiritually and economically. Services to meet the wellness needs should be

adequately supported to achieve these goals. Therefore, in the long-term, cost reductions will occur, and the health status of the population will improve.

3) **THE FIVE BASIC PRINCIPLES OF THE CANADA HEALTH ACT (1984) SHOULD BE PROTECTED AND ENDORSED:**

comprehensiveness	- delivery of a plan of insured services;
universality	- entitlement by all insured persons to the services provided by the provincial plan;
portability	- ability to receive insured services in another province or country, as approved by the provincial health plan;
accessibility	- ability to receive insured services without impediment;
public administration	- administered and operated on a non-profit basis by public authority, responsible to the provincial government and subject to auditing principles.

4) **THERE SHOULD BE GREATER RECOGNITION THAT THE DETERMINANTS OF HEALTH ARE OFTEN OUTSIDE THE REALM OF HEALTH PROGRAMS:**

There exists a broad range of factors that influence health. These include the social environment (where and how people live and work), adequacy and quality of nutrition, the genetic make-up of individuals, environmental conditions of

water, air and food, stress, self-esteem and the individual's ability to cope. Although it is not possible to identify all factors that impact on health, it is known that what "determines" health goes well beyond the health sector. It must be recognized that all of these factors are significant in society and affect the individual's health status. Therefore health policy development must consider not just the health sector, but those components that are outside (Evans & Stoddart, 1990).

5) **THE HEALTH SYSTEM SHOULD ENDORSE THE PRINCIPLES OF PRIMARY HEALTH CARE:**

Primary health care is defined as "essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and country can afford." (World Health Organization, 1978, p.34).

According to the Alma Ata Declaration (1978), the five (5) principles of primary health care are described as follows:

1) equitable distribution of health services to all populations to satisfy the essential health needs of the people;

2) maximum individual and community involvement in the planning and operation of health care services;

3) emphasis on services which are preventive and promotive rather than curative;

4) the use of appropriate technology;

5) the integration of health development with social and economic development.

6) **THE PROVISION OF HEALTH CARE SHOULD BE A PARTNERSHIP AMONG ALL SERVICE PROVIDERS:**

This principle supports:

* multidisciplinary health delivery models, that will make effective use of all health care providers; (for example: community health centres, prevention programs and home services);

* health care providers who will participate in decision-making at all levels of health care planning, including broad policy development as well as provincial and regional (community) levels;

* a broadening of the entry point to the health care system, that allows access to the most appropriate health care provider.

7) **COMMUNITY PARTICIPATION IN HEALTH CARE PLANNING SHOULD BE A VITAL COMPONENT OF THE SYSTEM:**

Responsibility and accountability for health care resources can be developed if those impacted by the decisions play a large role in the decision-making process. Community participation at the local level will keep the system "in touch" with the local needs and unique characteristics of

P.E.I. communities. The involvement of formal and informal groups and organizations at the community level will enhance the efforts of health promotion and public awareness of health care issues.

8) **EXPANSION AND INCREASED DEVELOPMENT OF COMMUNITY-BASED SERVICES SHOULD BE A KEY DIRECTION IN THE EVOLUTION OF P.E.I.'s HEALTH CARE SYSTEM:**

A series of factors contribute to the rationale for this system shift:

* For the person needing care, the social, medical, and community aspects are intrinsically linked. It is believed that assessment and care planning can be enhanced when carried out from a community-based setting or the individual's home environment.

* Community-based care models promote self-care and independence, as individuals continue to live in their own homes and take care of many of their own needs. This is particularly critical for seniors.

* Institutional care will be accessed only when community-based services are inappropriate either due to an episode of acute illness or care requirements beyond the capacity of home and/or community.

* Individuals can be returned home or to non-institutional settings at the most appropriate time, if adequate community-based services are in place.

* Community-based services can be a cost-effective alternative to institutional care, for some health care needs.

9) **PROVINCIAL POLICY DEVELOPMENT AND LEADERSHIP SHOULD PROVIDE THE DIRECTION AND PHILOSOPHY FOR THE DELIVERY OF HEALTH CARE SERVICES:**

Policy development and goal-setting should be carried out through the participation of health professionals, government and general public representatives. Health policy should emphasize health promotion and illness prevention strategies. Institutional and community based services should be provided, consistent with these provincial health policies and goals. Health policy should be broadened to include other sectors of government.

10) **HEALTH GOALS SHOULD BE EXPRESSED IN TERMS WHICH CAN BE MEASURED:**

All too often, health goals are measured by the number of health services provided such as, number of visits to clinics and number of hospital days. However, this does not provide the information for evaluating the achievement of goals.

In a managed health system, health goals must be identified in ways that can be measured. With such measurements, it would be possible to determine if health goals are being reached and which programs should be modified. This system of measurement or evaluation would be the mechanism to answer the questions, "is the system working?", or "are we doing the right thing?"

IV. TURNING THE VISION INTO REALITY

A. Structures for Change:

The Task Force believes structural changes are required to implement its VISION for health on PEI. It concludes that changes must occur at two levels: (1) policy and (2) management and delivery. These are described as follows:

1. *POLICY*

Within the health sector, there exists many organizations which develop and implement health policy. However, the co-ordination of these from a provincial perspective does not exist, resulting in unclear or conflicting priorities for health resources. Furthermore, other sectors of government develop policies which impact on health status.

The Task Force believes that a Provincial Health Policy Council is necessary to ensure the development of provincial policies and goals for health and of healthy public policy for all government sectors.

RECOMMENDATION:

Government establish a Provincial Health Policy Council

Structure:

Provincial Health Policy Council

Role:

Through legislated authority, to recommend and advise the Minister of Health regarding future direction of health policy, goals and standards for the province;

Tasks:

- Identify/assess relevant policy issues including both broad-based and specific policy areas;
- Develop health goals;
- Monitor/evaluate goals;
- Identify priorities and limitations;
- Develop healthy public policy;
- Promote broad public input in the development of health policy;
- Report annually to the Legislature;

Support to Council:

- The Council will require a Co-ordinator and a small administrative support staff to coordinate activities and access information. In addition, it must have access to resource staff from within the management structure.

Council Members:

- A maximum of 15 members, comprised of the following

  - Predominantly lay (public) representatives, five of which would be from the regional areas;

  - Representation from health professionals (including physicians, nurses and social workers), institutions and community-based services; These representatives will be appointed by their respective agencies;

  - Individuals from other sectors that impact on health policy (for example: education, environment, justice);

  - The Chairperson, appointed by government, will report to the Minister;

Legislation:

- Enabling legislation will be required to establish the Provincial Health Policy Council.

2. *MANAGEMENT*:

Presently, the management and delivery of health services takes place within a variety of structures, including three government organizations: Department of Health and Social Services, the Hospital and Health Services Commission and Addiction Services. In addition to this, there are a large number of community-based organizations, volunteer services and special interest groups that provide health services and management. The reporting structures and accountability of these are varied and include: direct reporting to the Minister; reporting to boards which are appointed by government; and reporting to autonomous boards.

This complex array of structures, over-laid with a variety of health providers delivering a wide range of services, truly contributes to a system that would challenge even the best of managerial skills.

The Task Force has identified that a single structure for management of the health care system is required to provide effective co-ordination and integration of services, flexibility to respond to the health care needs and accountability for the use of the resources. The Task Force believes this is consistent with its operating principle of a "provincial system of health care" and its mandate "to recommend a redesign of the health system's management and service delivery structures . . . that is consistent with the goals and objectives of an integrated provincial health care system."

The degree and speed of integration of the health sector to a single structure will require a step by step approach to allow all phases to be evaluated and well understood. This approach will further require extensive collaboration with all components of the health sector to ensure a high degree of success.

While the Task Force acknowledges the need for a tighter management structure, it also recognizes the need for regional organizations. The Task Force believes the community must participate in the development and delivery of their health services. The principle of public participation is a central component of primary health care. Leadership must be provided to establish these regional organizations.

RECOMMENDATION:

Government establish a Single Management Structure

The components of the single management structure and service delivery organization are described, as follows:

2.1 SINGLE MANAGEMENT STRUCTURE

Structure:

Single Management Structure, governed by a Board

Role:

To be accountable to the Minister for the management of the health care system and the provision of health services as directed by broad policy goals.

Specific Tasks:

- To manage the health care system, according to its legislative authority; management will have the flexibility to allocate resources based on need and to generate revenue for additional purposes;

- To deliver health services, consistent with the broad policy goals of government as recommended by the Provincial Health Policy Council;

- Develop operational plans and evaluate their outcomes; accountability will be enhanced through the establishment of operational policy which must be goal-oriented;

- Establish annual budget plans;

- To develop the regional and provincial management structures in co-operation with the health sector;

Board Members:

A maximum of 10 members, comprised of the following:

- lay (public) representatives;

- representation from health professionals (including nurses, physicians and social workers), institutional and community -based services; These representatives will be appointed by their respective agencies;

Reporting:

- the Board will report to the Minister through the Chairperson, who will be appointed by Government;

- Chief Executive Officer, initially appointed by Executive Council will report to the Board; Subsequently, the CEO will be hired by the Board;

Legislation:

- Enabling legislation will be required to establish the Single Management Structure;

2.2 SERVICE DELIVERY ORGANIZATION:

The Task Force recognizes that the public wish to become more responsible for their own health, and that of the community or region in which they live. The 600 service providers who participated in the five regional focus groups further confirmed their desire and willingness to work with the public in managing health services. The Task Force believes the organizational merits of community boards must be the basis for the development of a mechanism in the regions to achieve the following:

A. allow service providers and the public to work together to recommend regional priorities in health services, including the need for reallocation of existing funding;

B. identify deficiencies in health care in the regions and recommend on how they may be best met;

C. treat all elements of the health care system equally at the regional level;

D. provide a mechanism for the regions to recommend on provincial policies, through membership on the Provincial Health Policy Council;

E. provide recommendations for innovative approaches for the provision of health care, encouraging public participation and involvement of service groups;

F. facilitate the integration of services at the regional level.

The Task Force believes that the province should move toward a delivery system that includes community participation, and represents the full range of health services in that particular region. Time needs to be taken to plan and organize how this should happen.

The Single Management Structure will work to establish the regional organizations. The exact composition of these may vary in each area, depending on the needs. The speed of implementation will depend on the degree of readiness of communities. This will further mean that the role of existing boards may change as different roles may be assumed.

The Task Force cautions, however, that the details of how the regional organizations will work will require considerable discussion and study, prior to any implementation. It is also believed that much knowledge can be gained through the implementation of a regional board pilot project.

RECOMMENDATION:

The Single Management Structure establish a pilot project on Regional Organizations.

B. STRATEGIES FOR CHANGE:

In order to make the VISION a reality, the Task Force believes there are a number of issues which require immediate attention and the implementation of strategies for change:

1) *COMMUNITY NEEDS ASSESSMENT:*

To assist in the decision-making for allocation of resources, it is essential to know the needs of a community. The determination of these needs can be achieved through the use of a formalized assessment process and a health information system. This will help to establish the difference between the needs of the community and the demands of a community. Needs of specific target groups such as the elderly, pregnant teenagers and youth must be identified. Only then can goals, programs and services, responsive to public needs, be developed or re-directed appropriately.

RECOMMENDATION:

Community needs assessments be carried out to assist in planning of goals, programs and services.

2) *INFORMATION SYSTEM:*

If new strategies are to be developed and implemented, then the system must have the ability to evaluate these using accurate, timely and consistent data. If health policies and goals are to

be measured in terms of outcomes, then good data are essential. Any utilization studies, assessment of needs, alternate models of delivery, and evaluation of programs and technologies will require health data information. The system must have the information to make good resource allocation decisions and not have to rely on subjectivity or political agendas.

RECOMMENDATION:

A comprehensive health information system be established.

3) *ALTERNATE MODELS OF HEALTH CARE DELIVERY:*

Many alternate models of health care delivery have been piloted and successfully implemented in other areas of Canada and the United States such as health service organizations and community health centres. As well, there is extensive literature which supports their use. Such models, based on primary health care principles, can serve to broaden the entry point to the health care system, promote community-based services, reduce dependency on institutional care, emphasize health promotion and illness prevention, and allow multidisciplinary responsibility for health.

RECOMMENDATION:

That based on the principles of Primary Health Care, an alternate model of health care delivery, such as a Community Health Centre be developed and implemented on a pilot basis.

4) *UTILIZATION MANAGEMENT:*

The delivery of services within each region must occur as a coordinated system, fitting into local, regional and provincial levels. The utilization of resources for these services including beds, diagnostic services (e.g. lab, x-ray), medical technology, equipment, facilities, and health programs (institutional and community-based) must be managed in order to make the best use of available resources. Utilization management strives to achieve the best combination of service and quality with the available resources. Extensive program evaluation/information is required to determine how resources are being used This includes financial analysis, impact on health status, and assessment of the quality of care being provided. As recommended by the Role Panel Report (1991), appropriate assessment of services must be carried out to determine what services should be provided where and by whom. Only then can resources be allocated in an objective way to ensure the maximum in cost-effectiveness. Because of the significant amount of funding required to maintain institutional beds, there is a particular need to immediately assess the utilization of these resources.

RECOMMENDATION:

(A) Utilization management programs be implemented throughout the entire health care network of services.

(B) A mechanism be developed to determine the level and range of services appropriate to each region.

(C) In cooperation with the institutional sector, an immediate assessment of all institutional beds be carried out to determine the role, appropriate number, mix and distribution required for PEI. Future allocation of resources for institutional beds be based on the results of this assessment.

(D) All current capital construction projects for institutional beds be put on hold until the results of the bed utilization study are made known.

5) *ALTERNATE PHYSICIAN PAYMENT METHODS*

The high-cost fee-for-service system must be examined with a view to developing alternate ways of paying physicians. In recent years, many attempts have been made in Canada and the United States to change the fee-for-service system to alternate methods of payment. Although no true alternative to fee-for-service currently exists in Canada, there is a common consensus that a variety of methods of payment, depending on the health needs of the area, is probably the best alternative. Such alternatives consist of salary or capitation payments. As P.E.I. primarily pays physicians using the fee-for-service method, there is clearly potential to move to a variety of other payment models.

RECOMMENDATION:

In cooperation with the Medical Society, a pilot project on alternate physician payment methods be developed.

6) ***RESPONSIBILITY FOR ONE'S OWN HEALTH:***

The input of the service providers who participated in the five regional focus groups clearly identified the need for individuals to take responsibility for their own health. However, individuals must be given the information and empowered to make the decisions. They must know the costs and the limitations of the system. Health providers must encourage individuals to participate in decision-making. This will encourage individuals to develop not only personal accountability for health, but community and societal responsibilities.

RECOMMENDATION:

Educational programs be developed for the public to:
(1) assist them in making decisions which will promote wellness and reduce illness;
(2) better understand how the health system works and how it must be utilized in the most cost-effective way;
(3) encourage the public to be partners in health care decision-making by becoming active on public boards, volunteer health agencies, etc.

7) ***ROLE OF HEALTH PROFESSIONALS:***

If the people are to be the focus of the system, and health care is to be a multidisciplinary responsibility, then the roles of health professionals must be more clearly defined so everyone is working together, contributing their part to the system. Health professionals must work as a team and the team members must contribute appropriately, according to their skill, knowledge and expertise.

RECOMMENDATION:

In cooperation with the professional associations, the roles and functions of each of the health professionals must be examined to ensure that effective use is made of all health professionals, based on their skill, knowledge and expertise.

V IMPLEMENTATION STRATEGY:

The Task Force has prepared the following implementation strategy.

1. *LEADERSHIP*:

Upon release of the document, the leadership of the Single Management Structure and the Provincial Health Policy Council must be identified.

This leadership will become the nucleus of a transition team which will be struck to implement the recommendations of the Task Force report. This transition team, with representation from the health sector, must support the philosophy, direction and principles that have guided the work of the Task Force.

2. *POLICY*

An interim Provincial Health Policy Council must be established, through enabling legislation, by September 1992. The first year, the Council will develop health goals to be presented to the legislature in 1994.

3. *MANAGEMENT*:

At the provincial level, Addiction Services, the Department of Health and Social Services and the Hospital and Health Services Commission will begin to integrate to a single Management Structure, to be completed by 1995.

4. *REGIONAL:*

The implementation of a regional organization on a pilot basis should be operational by January 1993.

5. *LEGISLATION:*

It will be essential to review all legislation pertinent to existing management structures and draft new enabling legislation appropriate to the Single Management Structure and the Provincial Health Policy Council.

6. *EVALUATION:*

To ensure accountability, the implementation process will require evaluation of each step until the process is complete.

VI. SUMMARY OF RECOMMENDATIONS

* Government establish a Provincial Health Policy Council.

* Government establish a Single Management Structure.

* The Single Management Structure establish a pilot project on Regional Organizations.

* Community needs assessments be carried out to assist in planning of goals, programs and services.

* A comprehensive health information system be established.

* That based on the principles of Primary Health Care, an alternate model of health care delivery, such as a Community Health Centre be developed and implemented on a pilot basis.

* UTILIZATION MANAGEMENT:

  (A) Utilization management programs be implemented throughout the entire health care network of services.

  (B) A mechanism be developed to determine the level and range of services appropriate to each region.

  (C) In cooperation with the institutional sector, an immediate assessment of all institutional beds be carried out to determine the role, appropriate number, mix and distribution required for PEI.

Future allocation of resources for institutional beds be based on the results of this assessment.

(D) All current capital construction projects for institutional beds be put on hold until the results of the bed utilization study are made known.

* In cooperation with the Medical Society, a pilot project on alternate physician payment methods be developed.

* Educational programs be developed for the public to:

(1) assist them in making decisions which will promote wellness and reduce illness;

(2) better understand how the health system works and how it must be utilized in the most cost-effective way;

(3) encourage the public to be partners in health care decision-making by becoming active on public boards, volunteer health agencies, etc.

* In cooperation with the professional associations, the roles and functions of each of the health professionals must be examined to ensure that effective use is made of all health professionals, based on their skill, knowledge and expertise.

APPENDIX "A"

OPERATING PRINCIPLES

* That health services be organized as a provincial system of health care.

* That policy leadership be consolidated and reflect a clear direction and focus.

* That organizational structure and service functions designed to provide care be accountable to policy goals and standards.

* That the changes reflect financial and resource efficiency: duplication, redundancies, conflicts and barriers that seem to be "built-in" to the current system be reduced or eliminated.

* That community-based and patient-centered services be further explored and strengthened; the system should be designed to reflect and respond to the health needs of the community and the individual, not the organization's needs.

* That the system place less emphasis on the development of institutional beds and more emphasis on the development of alternate models of providing health care and treatment.

APPENDIX B

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SECTION "B"

MEEINGS/PERSONAL INTERVIEWS

The Chairperson, of the Task Force on Health, held meetings or personal interviews with the following:

- Association of Nurses of Prince Edward Island - Council members;
- Licensed Nursing Assistants' Association of P.E.I.;
- P.E.I. Medical Society Board;
- P.E.I. Advisory Council on the Status of Women & representatives of five women's groups and agencies;
- Dr. Joan MacIssac;
- P.E.I. Dental Association Board;
- Each member of the Task Force on Health;
- Senior Directors of P.E.I. Hospital and Health Services Commission and the P.E.I. Department of Health & Social Services;
- Federation of Labour representative, Sandy McKay.

APPENDIX "C"

MAJOR THEMES OF FOCUS GROUPS

Five regional meetings were held across the province in the following locations:

West Isle Senior High School, Alberton
Three Oaks Senior High School, Summerside
Holland College, Charlottetown
Montague Legion Hall, Montague
Souris Health Centre, Souris

Over 600 health providers participated in small groups to discuss five questions. The major themes are summarized as follows:

1. **IN YOUR MIND, WHAT DOES IT MEAN WHEN WE SAY WE SHOULD TAKE RESPONSIBILITY FOR OUR OWN HEALTH?**

   - Practice healthy lifestyles regarding smoking, diet, exercise and environment; promote healthy lifestyles through educational programs in schools;
   - Public should be better informed, ask for options and be part of the decision-making; recognize when something is wrong; know the limitations of the system;
   - It is not necessary to seek medical intervention for all ills;
   - Health providers must become role models for healthy lifestyles;
   - Primary focus of health system should be health promotion and illness prevention with an emphasis on wellness;
   - Professional marketing for education of public and health providers.

2. **WILL TAKING RESPONSIBILITY FOR OUR OWN HEALTH HAVE COST SAVINGS ON OUR HEALTH CARE SYSTEM? (IDEAS)**

   - Decreased utilization of services will occur if the public is educated on other ways of accessing the system and meeting the health needs of the community;
   - Costs can be reduced if consumers' needs are met prior to the requirement of expensive services, i.e. through the use of prevention, support services, education and screening programs;
   - Tax system can be used as a motivator by providing tax credits to those who do not use the health system;
   - Invoices on services used and costs incurred should be provided to each consumer at the end of the year.

3. **FREQUENTLY, WE APPEAR TO WORK IN ISOLATION OF ONE ANOTHER. WHAT KINDS OF CONDITIONS WOULD INCREASE OUR WORKING TOGETHER AND ENSURE THAT OUR OBJECTIVES ARE COMPLEMENTARY?**

- Establish and communicate organizational goals and objectives;
- Clearly define the roles of all the players, as to who should be doing what;
- Provide clear top-down direction with bottom-up feedback and extensive involvement in decision-making;
- Improved communication among and between all groups (Department of Health and Social Services, Hospital and Health Services Commission, Addiction Services, Hospital Associations);
- Fast response from support services;
- Opportunities, similar to the focus group meetings, must be provided to share information, ideas, concerns and solutions;
- Reduce duplication, hierarchy and red tape;
- Team approach to assessments;
- Patient or client-centered care; focus on needs of the patient;
- Standardization of policies and procedures, with clear goals;
- Computerized health information system;
- Lateral moves (secondments) of staff to other areas;
- Increased collaboration of health providers to determine community needs;
- Greater availability of physicians to assist in care planning for support services;
- Shared in-service educational activities among staff of different organizations;
- More working together -- the concept of an area health council.

4. **THE PRESENT HEALTH CARE SYSTEM IS ILLNESS-ORIENTED, AND, TO SOME DEGREE, ILLNESS WILL ALWAYS BE PART OF THE SYSTEM. HOW DO WE, AS A COMMUNITY, MOVE THE FOCUS SO THAT ISSUES OF HEALTH PROMOTION AND COMMUNITY HEALTH ARE SEEN AS PRIORITIES?**

- Multidisciplinary health centres in communities;
- Improved support systems -- call lines for advise on health issues;

- Begin health education at an early age;

- Educate people as to where to go to ask for help;

- Broaden the entry point to the health care system to allow the public to access health providers other than physicians, depending on the need;

- Agreement among all health professionals and organizations that health promotion is a priority;

- Public must take an active role in taking responsibility for their own health;

- Seek community input on how dollars should be spent;

- Focus on wellness -- use of wellness clinics, fitness classes, screening programs;

- Media promotion for healthy lifestyles;

- More resources directed into health promotion activities;

- Examine/explore user fees;

- Public workshops to increase awareness of health issues;

- Regional boards to coordinate services at the community level.

5. **HOW DO WE WORK TOGETHER WITH THE COMMUNITY TO ENCOURAGE IDENTIFICATION OF NEEDS? HOW DO WE INVOLVE COMMUNITY IN MEETING NEEDS?**

- Community must identify its health needs; health forums could be used to do this;

- Inform the community;

- Encourage the community to participate in decision-making;

- Increase community awareness of health issues;

- Provide information to the community on the costs of the health care system;

- Community must speak with "one voice" -- services should be coordinated under one umbrella, e.g. elected board;

- More representation from community groups (e.g. Home and School, self-help groups, Alcoholics Anonymous, Diabetics) for decision-making;

- Ensure accountability by the decision-makers;

- Community must become proactive;

- Use of public forums, questionnaires;

- Decentralized authority and decision-making regarding community health services;

- Team approach to assessment of community needs; focus on needs of the community and not the individual;

- Effective leadership should be provided.

6. **THE FUTURE WILL REQUIRE GREATER PARTICIPATION OF HEALTH PROVIDERS IN POLICY DEVELOPMENT AND DECISION-MAKING, WHETHER IT IS EXPLORING NEW WAYS IN DOING SOMETHING, OR IN THE IDENTIFICATION OF IDEAS FOR COST CONTAINMENT. HOW DO YOU SEE THIS PARTICIPATION HAPPENING?**

- Request input and allow community advice to have an impact on decision-making;

- Bottom-up decision-making; allow people to make decisions;

- Leadership is key;

- Long-term planning to financial cutbacks;

- "Flatter" organizations;

- Support from senior management for total quality management;

- Participation and input is required by:

    - professional organizations;
    - multidisciplinary groups in the workplace;
    - multidisciplinary task forces;
    - regional boards; and
    - information-sharing sessions.

- Staff representation on boards and other decision-making bodies;

- Less politically-oriented planning;

- Input requested from all health providers on how the system should work;

- Need for better communication with government bureaucrats who must take the opinion of health providers seriously;

- Improved communication among health providers;

- Working together of all organizations.